

Vulnerable, single and living in poverty: Women's challenges to accessing food in the Australian Capital Territory

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Access to food is a basic human right.¹ Yet, reports indicate that many Australian women do not receive this entitlement. Women's access to food is challenged due to financial stresses, poor income and employment, low education, gender power inequalities, single parent household status and exposure to psychosocial difficulties such as homelessness and domestic and family violence.²⁻⁵ In 2013–14, 14% of all Australian women were reported to be living in poverty and, of those Australians experiencing poverty, 53% are women.⁶ This is perhaps not surprising given that, although women account for approximately 46% of the Australian workforce, their average weekly full-time wage is 18% lower than males.⁷ More women are also employed in part-time employment⁷ due to caregiving roles, thus decreasing their income capacity. While low income is a strong predictor of food insecurity,⁶ single parent status, the rising cost of living and unaffordable housing options are forcing individuals, especially women not previously at risk, to reprioritise basic living expenses over food.^{6,8} Limited access and consumption of food has been linked to short- and long-term health problems such as: nutrient deficiencies (for example iron and calcium); weight loss or overweight and obesity; poor dental health; type 2 diabetes; and mental health problems.^{9,10}

Food and nutrition security "exists when all people at all times have physical and economic access to food, which is safe

Abstract

Objective: To explore challenges to food access faced by vulnerable women living in the Australian Capital Territory and surrounds.

Method: Qualitative study comprising semi-structured interviews supplemented with quantitative demographic data.

Results: Forty-one women, mean age of 43 years, living in government and community housing who had an income of <\$300 per week participated. A total of 78% of women had completed Year 10 or above and 93% had accessed food from at least one charitable organisation. Women requested greater and reliable access to meat, dairy and quality fruit and vegetables. Primary challenges to accessing food included: limited income, distance to food outlets, lack of nutritious, safe and healthy food, limited knowledge of services and opening hours.

Conclusion: Access to safe, nutritious and healthy food is difficult for women living in poverty. Acknowledgement of challenges that contribute to women's food insecurity by all stakeholders is essential to address the problem and build sustainable actions and solutions.

Implications for public health: Collaboration from all stakeholders within our food system is required to address current inequities to accessing reliable, nutritious and safe food and to reduce individual food insecurity.

Key words: food insecurity, food access, vulnerable women, Australia

and consumed in sufficient quantity and quality to meet their dietary needs and food preferences, and is supported by an environment of adequate sanitation, health services and care, allowing for a healthy and active life".¹¹ Food insecurity ranges from worrying about where the next meal may come from, to difficulties accessing adequate nutritious food, or to severe levels of hunger or malnourishment.^{12,13} The Australian Health Survey (2011–12) states that 4% of Australians were living in a household that had run out of food in the previous 12 months.¹⁴ National Australian data outlining this problem is

limited and likely to under-represent the full extent of the problem due to limitations in the methodology.^{13,15} In addition, these data do not separate prevalence of food insecurity by gender. Reports from key relief organisations, however, suggest that an increasing number of women require assistance from charitable food organisations. The Salvation Army National Economic and Social Impact report¹⁶ states that 68% of survey respondents (total n=1,600) who used their emergency relief services were women, while Foodbank Australia reported that 34% of women who used their services were food

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Submitted: March 2018; Revision requested: August 2018; Accepted: October 2018

The authors have stated they have no conflict of interest.

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Aust NZ J Public Health. 2018; 42:541-6; doi: 10.1111/1753-6405.12845

insecure.¹⁷ These statistics are only a guide and do not fully capture women who: are worrying about where the next meal comes from; use other charitable food services; are 'hidden' due to safety reasons; use a variety of purchasing strategies to enable value for money; and acknowledge their situation. Further, this data does not capture the gender specific transient nature of emergency food relief requirements.^{12,13,18}

There is a widely held perception that the Australian Capital City (ACT) is a 'wealthy' city.¹⁹ However, in 2011–12, 3.6% of ACT households were reportedly food insecure,²⁰ levels similar to those reported nationally. Of those living in sole parent families in the ACT, 80% were made up of women.²¹ Further, the ACT recorded the second-highest level of homelessness in Australia (50/10,000 people homeless) with 45% of these being women,²² and 11% of ACT households were reportedly living in poverty in 2016.¹⁹ In the ACT region, there are between 60 and 70 agencies providing relief to people in need.²³ In addition to offering a safe refuge and health and legal services, these organisations provide food in the form of emergency food parcels, regular meals or an opportunity to purchase food cheaply through food pantries and, on occasion, food vouchers.²⁴ These agencies include emergency relief organisations, religious and community organisations, and government and non-government organisations such as food hubs and pantries, soup kitchens, charitable meal providers and welfare organisations.

There are currently no data describing the status of food security and the challenges to food access of vulnerable women in Australia, including those in the ACT. The aim of this study was to explore where vulnerable women living in the ACT and surrounds accessed food, the challenges vulnerable women faced when accessing adequate and nutritious food, and how these challenges influenced food choices.

Methods

Study design and participants

A qualitative study supplemented with quantitative demographic data was conducted. Single women living alone (with or without children), in government or community accommodation (for example: refuges, public/government or private rentals) from the ACT region, Australia, and living on low incomes were invited to participate

in the study during July to October 2017. Participants were recruited through a variety of charitable food organisations across the ACT region to ensure representation from different geographic areas and organisation types. The aim was to recruit between 40 and 45 participants to capture the diversity of participant experiences, or until data saturation was achieved. Managers of charitable food organisations were invited to assist with recruitment by approaching women directly or through distribution of a flyer. Participants were either interviewed at the charitable food organisation (n=38) or their home (n=3). Interviews at the organisation were conducted in a quiet area or office, took between 20 and 30 minutes and were transcribed by the primary researcher at the time of the interview due to surrounding noise. Interviews conducted in the participant's home were recorded and later transcribed by a transcription company.

Data collection

The women participated in a one-on-one semi-structured interview. Interview questions focused on: the location and types of food obtained and purchased; factors that challenged food access; the types of foods participants would like to access; and distance to food outlets. Demographic data included: age; education level; income; living status (alone, with dependents, etc); number of children; health status (dental problems, overweight and type 2 diabetes); and risky behaviours (smoking and alcohol consumption).

Data analysis

Quantitative data were analysed using IBM SPSS Version 23. Basic descriptive analysis, including mean scores, standard deviations and standard errors, and a chi-squared analysis was conducted on the demographic data. Qualitative data analysis was conducted using a combination of qualitative description²⁵ and an inductive approach in which data themes²⁶ were derived for the responses, in particular those relating to the challenges to food access. Qualitative description was primarily used due to the sensitive nature of the topic for the women included in this study, which meant that interview questions were directive rather than exploratory. All data analyses were conducted by TL and checked by PU and AD.

Ethical considerations

This study was conducted according to the guidelines outlined in the Declaration of Helsinki. Ethical approval was granted by the University of Canberra Human Research Ethics Committee (16-243). Written informed consent was obtained from all participants. Participants were given a \$25 supermarket voucher as a thank you at the completion of the interview.

Results

Forty-one women participated in the study. Table 1 outlines participant characteristics. The average age of the women was 42.8 years (SD 11.3) with participants aged between 19 and 71 years. Fifty-six per cent of women (n=23) had between one and four children. All but one woman relied on social security payments and 48.8% (n=20) received a weekly income of ≤\$300. The level of completed education ranged from primary school year six (n=1, 2%) to university (n=9, 22.0%) and 80.5% of women had completed Year 10 or above. At the time of the interview, three women were enrolled in courses: Certificate IV in Community Services (n=2), and Certificate IV in Education Support (n=1). The women lived in a variety of accommodation from government and community housing (n=22, 53.7%) to owning their own home (n=5, 12.2%). Low income as a result of marriage breakdown, escaping domestic violence, disability and extreme debt was identified as the main reason for requiring assistance.

Twenty-five (61.0%) women reported smoking cigarettes and more than half (53.7%) consumed alcohol, with 13 (32.0%) reporting consumption of both. Smokers on average smoked 10 cigarettes/day (range 2–30/day), whereas alcohol was consumed during social or special occasions (n=12/22). Thirty-eight (92.7%) women reported having two or more health conditions and nine (21.9%) reported five or more. More than half reported having dental problems (n=23, 56.1%), being overweight (n=22, 53.7%), and/or having a mental health/depression condition (n=30, 73.1%).

Twenty-nine women (70.7%) stated they had received some form of social support from family, friends, the refuge, their caseworker or people they had met who had been in similar situations. While this support was available, six (14.6%) women stated they would not ask for assistance from their family and friends due to stigma or embarrassment.

Accessing food and type of food

The women accessed food from a variety of charitable food organisations (emergency relief centre, food pantry), supermarkets and other food outlets such as discount variety stores, butchers and fresh food markets. Five women (12.2%) received food from friends and neighbours and two women (4.9%) gambled at local licensed club raffles to win meat trays. Five women (12.2%) admitted to stealing food from either a supermarket (n=3, 7.3%) or their child's playgroup (n=1, 2.4%), or engaged in dumpster diving and searching through bins (n=1, 2.4%). Thirty-eight women (92.7%) accessed food from at least one charitable food organisation with 46.0% (n=19) accessing food from two or more pantries or emergency relief centres. Only six women (14.6%) attended food charities that offered a meal. Other participants reported not accessing these services, due to: feelings of being uncomfortable or not safe in the setting; limited or no food choice; associated stigma; and, feeling that "I'm not that low yet". Charitable food was often sourced first, then supplemented with food purchased from supermarkets and discount variety stores. Participants were more likely to shop at the supermarket closest to their home, with discount supermarkets preferred. The women employed budgetary strategies including: sourcing reduced priced food items; shopping around major events such as religious festivals; using supermarket loyalty programs to receive extra savings; and searching supermarket or retail store catalogues for discounted product lines.

The food accessed was dependent upon what was available at the charitable organisation or on sale at the supermarket. There was little difference in the type of food obtained from the charitable food organisations and that purchased from other food outlets. Fruit and vegetables from the charitable food organisations were usually free; however, quality and amount available each visit varied, for example: one bucket or 1–3 pieces of fruit and/or vegetables, or a weekly hamper comprising 75% fruit and vegetables. Women therefore relied on supermarkets to purchase additional food and a greater variety of fruit and vegetables. From the food pantries, women purchased staples, complementary items (such as pasta and a sauce) or foods that were normally expensive in the supermarket, such as cereals and school lunchbox treats. Similarly, women accessed staple items, albeit less

Table 1: Study participant characteristics (n=41).

Characteristic	N (%)
Age (mean years) ^a	42.76 (11.3)
Income	
Newstart	14 (34.1)
Disability Allowance	13 (31.7)
Parenting Payment	9 (22.0)
Widows/Foster/Carers and Aged Pension	4 (9.6)
Other, Income from another source	1 (2.4)
Average Weekly Income	
\$101–\$200	3 (7.3)
\$201–\$300	17 (41.4)
\$301–\$400	7 (17.1)
>\$400	14 (34.1)
Highest Education Level completed	
Primary – Year 6	1 (2.4)
High school Year 8/9	7 (17.1)
High School – Year 10	20 (48.7)
High school – Year 12	3 (7.3)
University	9 (22.0)
Overseas education	1 (2.4)
Accommodation	
Refuge	5 (12.2)
Government/Public Rental/Community Housing	22 (53.7)
Private Rental	4 (9.8)
Own Home/Mortgage	5 (12.2)
Family/friends/other	5 (12.2)
Ever been homeless, yes	29 (70.7)
% with children	23 (56.1)
Average number of children#	2.61 (1.32)
Smoker, yes	25 (61.0)
Drinks alcohol, yes	22 (53.7)
Health conditions	
Type II diabetes	6 (14.6)
Overweight	22 (53.7)
Dental Problems	23 (56.1)
Mental Health	18 (43.9)
Depression	22 (53.7)
High Blood Pressure	6 (14.6)

Note:

a: Mean ±SD

frequently, from emergency relief centres. Access to meat products from charitable food organisations was limited and included small packages of mince, sausages, fish and chicken drumsticks. To supplement meat obtained from charitable food organisations, women purchased meat from supermarkets when on sale, or at times went without. Perishable food items such as yoghurt, cheese and milk were rarely available from charitable food organisations and had to be purchased. As a result of limited charitable and discounted

choices, some women indicated their food choice had changed from nutrient-dense to energy-dense foods.

The women advised they would like access to foods that provide greater nutritional value, such as: meat, including steak, chicken and pork (n=24, 58.5%); regular availability of fresh vegetables (n=17, 41%); dairy food, in particular yoghurt and cheese (n=11, 26.8%); and regular availability of fresh fruit (n=9, 21.9%). Those with severe dental problems (n=5, 12.2%) requested access to softer fruits and vegetables as many of the charitable fruits and vegetables choices were difficult to eat. Eight women (19.5%) stated they would like to have greater access to discretionary type foods, for example: school snacks, chocolate, chocolate biscuits and coconut-based products. Other women stated it was difficult to access foods when on a special diet or with a health condition, for example, requiring lactose- or gluten-free foods, as choices were limited or not available.

Challenges to accessing food

The challenges to accessing food are described by seven key themes with subthemes, these are: Limited income; Transport; Nutritious safe and healthy food; Health; Lack of service knowledge; Impact of charity; and the Personal environment. Figure 1 outlines the challenges to accessing food by themes and subthemes and the following describes the commonly mentioned challenges under each theme. The primary challenge for accessing food was a lack of income after paying rent, utilities, outstanding debts and expenses related to children's education and sporting costs. Highlighting the need to prioritise income and food, one mother stated, "I miss meals so my kids are able to do activities".

Distance was a challenge regardless of available transport as the women travelled an average of five kilometres (one way) to access food either by car (n=24, 58.5%) or a combination of buses and walking (n=17, 41.4%). While supermarkets were usually within a two- to four-kilometre radius (one way), women travelled on average 12 kilometres (one way) from their accommodation to access food from a charitable food organisation. The main challenge for those with a car was having enough money for fuel and other associated motor vehicle costs. For those relying on public transport and walking, bus fares were a barrier, as were limitations on the amount

The hours and location of charitable food organisations limited accessibility to discounted or free food. The operating hours competed with children's activities, transport options and working hours, thus women reported missing access to reduced-cost food. Other charities were open at night, but

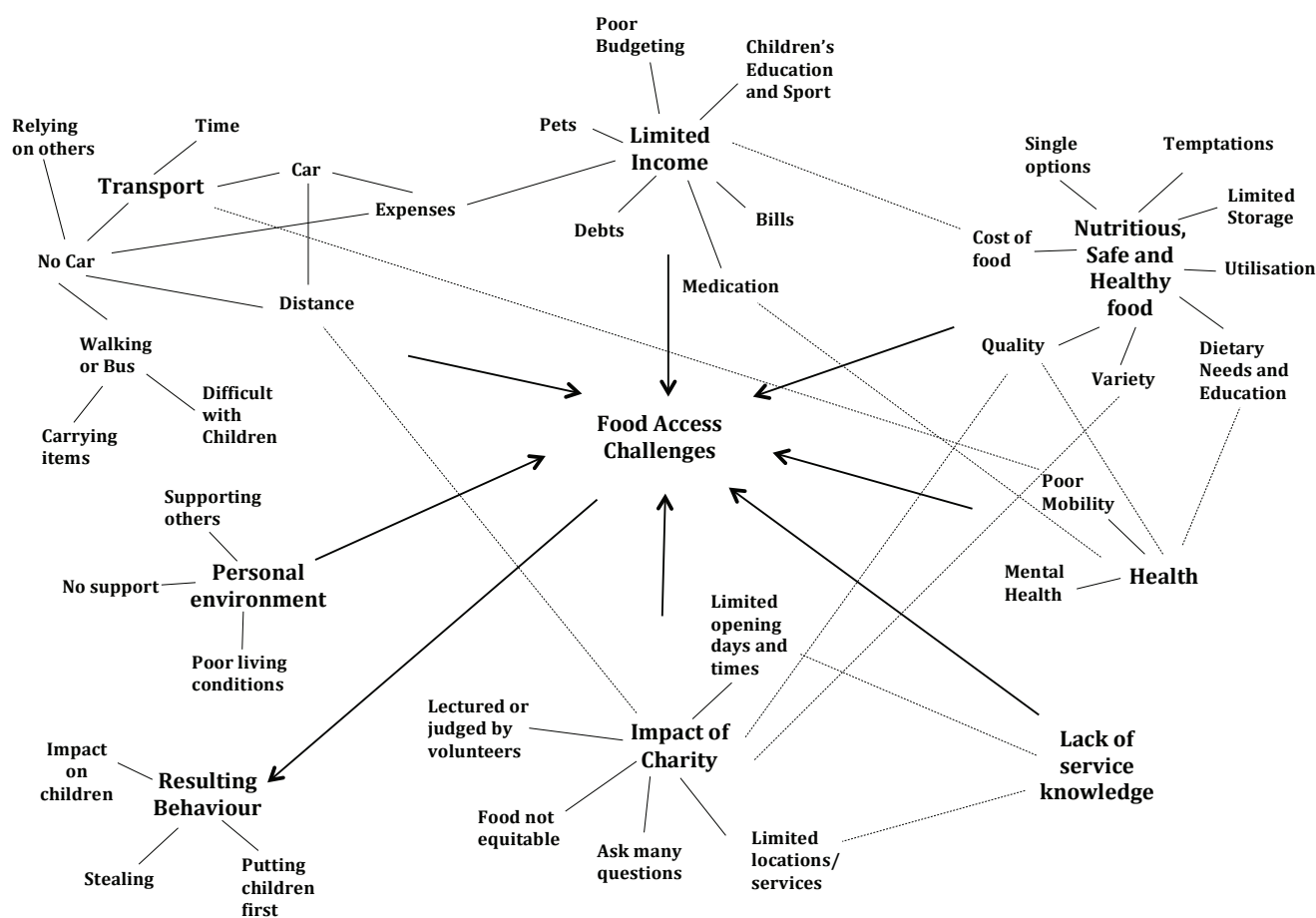
Things are not close to where I live, and the timing does not always suit, for example the closest [agency] is open one day a week for two hours; this interferes with children's sports and when you are there you spend most of the time in a line. Another is too far, and I have to use petrol and the time to get there.

Other factors limiting access to food included: the health of the woman, in particular their mental health or mobility status; having to support other family members; or having no support; and living in shared accommodation. The women indicated a lack of knowledge about what services were available and where they were located. There were also comments regarding the lack of services for single women with no dependents and women aged 40-plus years. Many women stated that government services or case managers did not specifically advise about food services and, in many cases, they only found out about them by "accident":

It's very unfair saying to people, "You only have to ask" because it's not the case. You

To cope with limited food, women put their children first and ate either smaller portions, leftover scraps or nothing at all. One mother stated: "I go without for the kids and when hungry I binge on mashed potato". Others resorted to stealing food. Throughout the interviews, many women mentioned being embarrassed by their current situation and the stigma of using charitable food services. Once aware of the available services, it then took a while to accept assistance, and they would only use services when they were desperate or had nowhere else to go. As one woman stated, "suddenly having to be reliant on a food kitchen or something like that is a little bit of a culture shock". Stereotyping was also an issue, with many women referring to themselves as "people like us", while another woman stated, "people don't know the history; they're quick to judge."

Figure 1: Visual representation of the food access challenges.



Note:
Themes are in bold, sub-themes normal text. Solid lines show link between themes and related sub-themes, dotted lines show link between sub-themes and another theme)

Despite these feelings, when given supermarket vouchers from emergency relief organisations, a small number of women felt some level of empowerment:

I felt great that day driving down to the shops with those EFTPOS cards [supermarket vouchers] and being able to make the choice of what I wanted and to have a nice meal for the boys that night.

Importance of food and cooking

The women were asked questions relating to the importance of cooking. Thirty-three women (80.5%) had access to their own kitchen, while the remaining eight women (19.5%) shared a kitchen with other residents. Regardless of kitchen type, all but one woman (2.4%) had access to a stove and fridge, and all had access to a microwave and varying cooking utensils. In relation to cooking, 18 women (43.9%) stated they loved cooking, 14 (34.1%) liked cooking, five (12.2%) cooked just so they could eat and the remainder (9.8%) did not like cooking. When cooking, 21 women (51.2%) stated they created a dish from anything, while 15 (36.6%) either used recipes or were able to create a dish from what was available. Women engaged in many strategies to ensure food would last, including: experimenting with unfamiliar foods and combinations; freezing surplus fruits and vegetables; and sharing food with others in similar situations. Generally, cooking evoked positive emotions of enjoyment and happiness, was viewed as relaxing, and contributed to the women feeling confident and capable. For some though, their perception of cooking had changed due to the shame of being unable to cook due to poor food access or unable to buy foods they liked to feed children, family and friends.

Food was important for the women's health and wellbeing. For those with children, food was a way to engender healthy habits for their children regardless of the situation. For some women, food was seen as: nourishing, social, healthy, energy, a priority, life, smiles, happy belly – happy life, and bringing family together. The word food was also associated with: shame, embarrassment, lack of modelling, increased weight, not enjoyable and a "means to an end". As two women explained:

I had to steal food a couple of times to support my adult son because I had none. Both times I was caught. I was so ashamed.

I did not know where to go. A friend found out where to go. But I felt shame, loss of pride and

overwhelmed to go as my friend told me that you have to line up and you are given a bag.

Discussion

Understanding the problem of women's challenges to accessing foods, as described by those with lived experience, facilitates an innovative and inclusive way in which to foster advocacy. It is widely acknowledged that low income and thus poverty is the underlying issue to food insecurity,⁶ so it is not surprising that a lack of disposable income was identified as a challenge to purchasing and accessing food in this study. While a number of challenges to accessing food were identified, two are worthy of note. Firstly, the location of charitable food organisations and distance many women travelled to access discounted food should be considered in the context of healthy built environments. This is particularly important within the ACT context, given the peppering of low-income households throughout suburbs that do not have the food environment to support the diversity of socioeconomic structure.¹⁹ Secondly, the intermittent availability of fresh, safe and nutritious food impacts upon women's access to food and subsequent food choices. While food is accessible from a variety of sources, charitable organisations are preferred due to the availability of free or reduced-cost food. However, the quality and type of food available is dependent upon donations, with food mostly high in energy and/or limited quality. Vulnerable women require regular access to affordable nutritious food from these and other sources, such as supermarkets.²⁷ Further to this, a recent international scoping review²⁸ reported that users of food banks valued the service and volunteer support but experienced negative feelings relating to poor food quality and choice and the social stigma associated with using food banks. Middleton et al.²⁸ also found that using food banks was often associated with a loss of self-esteem and feelings of powerlessness. The women we spoke to also admitted to feelings of shame and embarrassment at having to access food banks. However, while no-one specifically stated that the use of food banks was associated with lower self-worth or a loss of control over their situation, this was implied through the empowerment some women described when they were provided with vouchers to use at local supermarkets.

Thus, addressing current inequities to accessing reliable, nutritious and safe food is of high priority for psychosocial as well as physical health reasons and requires input from all stakeholders within our food system.

Despite the women in this study living below the poverty line (a criterion for participation) the age range of women requiring assistance was diverse, ranging from 19 to 71 years, and three-quarters (80.5%) had completed year 10 or above, with nine (22.0%) women having completed university. Thus, in many ways these women did not fit the profile of the 'typical' food bank user who is often perceived to be young and uneducated.²⁸ Further, the majority of women (78%) reported enjoying cooking and all had access to kitchen facilities. This finding is in line with those of Huiskens et al.²⁹ who demonstrated that adults in food insecure households had similar food preparation skills and cooking abilities to adults in food secure households. Despite public perception,³⁰ the women wanted increased access to nutritious foods and articulated the importance of food on their own and their dependents' health. Similar to Butcher et al.³¹ the profile of women in this study further suggests that situational events, such as domestic violence or marriage breakdown, have greater impact than personal choice on accessing charitable services. Thus, understanding and acknowledging the changing and expanding demographic of food insecurity by stakeholders is imperative for the implementation of targeted, effective and sustained action.

Identified limitations relate to the exclusion of other questions in the interview schedule, such as: ethnicity, frequency of travel to each food outlet, income spent on food and whether health conditions presented before or after vulnerability. It may also be argued that the offer of a \$25 'thank you' voucher influenced the women to participate. However, many women were surprised and grateful when presented with the voucher at the completion of the interview. Finally, the variation in determinants of food security in regional and remote communities³² limit the generalisability of these findings to a broader context and thus should be interpreted with caution. Despite limitations, these findings do have merit for the context in which they have been studied and are useful for strategic direction in the place-based setting.

Conclusion

This study explored, from the perspective of the participants, challenges that single women living in poverty in an Australian capital city face when accessing food; places where food is accessed; and strategies undertaken to access food. Despite an outward perception of wealth, cities such as that studied here need to undertake a cohesive and inclusive approach with stakeholders at all levels to address United Nations sustainable development goals of: no poverty, zero hunger, good health and wellbeing, reduced inequalities and gender equality. Greater recognition and reach in terms of the role of food security in policy areas, within the food system and across stakeholder levels is needed for sustained change.

Acknowledgements

The authors acknowledge and thank the charitable food organisations that allowed us to interview their clients. We also thank the women for sharing their stories and providing us with an insight into a difficult and sensitive area.

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Supporting Information

Additional supporting information may be found in the online version of this article:

Supplementary Table 1: Where and type of food vulnerable women received and/or purchased.

Supplementary Table 2: Analysis of challenges to accessing food by vulnerable women.